COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1075, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, line 6, delete "if all of the" and insert "**if:**

(1) the waiver period does not exceed ten (10) years; and

(2) all of the following conditions are met:".

Page 1, delete line 7.

Page 1, line 8, delete "(1)", begin a new line double block indented and insert:

"**(A)**".

Page 1, line 12, delete "(2)", begin a new line double block indented and insert:

"**(B)**".

Page 1, line 13, delete "(A)", begin a new line triple block indented and insert:

"**(i)**".

Page 1, line 14, delete "(B)", begin a new line triple block indented and insert:

"**(ii)**".

Page 1, line 15, beginning with "include" begin a new line double block indented.

Page 2, line 1, delete "(3)", begin a new line double block indented and insert:

"**(C)**".

Page 2, line 2, delete "(A)", begin a new line triple block indented and insert:

"**(i)**".

Page 2, line 3, delete "(B)", begin a new line triple block indented and insert:

"**(ii)**".

Page 2, line 4, beginning with "do" begin a new line double block indented.

Page 2, line 5, delete "(4)", begin a new line double block indented and insert:

"**(D)**".

Page 2, line 8, delete "(5)", begin a new line double block indented and insert:

"**(E)**".

Page 2, line 8, delete "to review the waiver upon request if:" and insert "**to:**

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 2, delete lines 9 through 16.

Page 2, line 17, delete "(6)", begin a new line double block indented and insert:

"**(F)**".

Page 2, line 21, delete "(7)", begin a new line double block indented and insert:

"**(G) The waiver of coverage does not apply to coverage required under state law.**

(H)".

Page 2, line 25, delete "(1)" and insert "**(2)(A)**".

Page 2, line 26, delete "(2)" and insert "**(2)(B)**".

Page 2, between lines 39 and 40, begin a new paragraph and insert:

"**(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:**

(1) written notice under subsection (a)(2)(A); and

(2) offer of coverage and policy under subsection (a)(2)(B).

(d) An individual who is covered under a policy that includes a waiver under subsection (a) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(e) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(f) Upon the expiration of the waiver period allowed under this section, the insurer shall:

(1) remove the waiver;

(2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) renew the policy in accordance with 45 CFR 148.122.".

Page 3, line 10, delete "if all of the following conditions are met:" and insert "**if:**

(1) the waiver period does not exceed ten (10) years; and

(2) all of the following conditions are met:".

Page 3, line 11, delete "(1)", begin a new line double block indented and insert:

"**(A)**".

Page 3, line 15, delete "(2)", begin a new line double block indented and insert:

"**(B)**".

Page 3, line 16, delete "(A)", begin a new line triple block indented and insert:

"**(i)**".

Page 3, line 17, delete "(B)", begin a new line triple block indented and insert:

"**(ii)**".

Page 3, line 18, beginning with "include" begin a new line double block indented.

Page 3, line 21, delete "(3)", begin a new line double block indented and insert:

"**(C)**".

Page 3, line 22, delete "(A)", begin a new line triple block indented

and insert:

"**(i)**".

Page 3, line 23, delete "(B)", begin a new line triple block indented and insert:

"**(ii)**".

Page 3, line 24, beginning with "do" begin a new line double block indented.

Page 3, line 25, delete "(4)", begin a new line double block indented and insert:

"**(D)**".

Page 3, line 28, delete "(5)", begin a new line double block indented and insert:

"**(E)**".

Page 3, line 28, delete "to review the waiver upon request if:" and insert "**to:**

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 3, delete lines 29 through 36.

Page 3, line 37, delete "(6)", begin a new line double block indented and insert:

"**(F)**".

Page 3, line 42, delete "(7)", begin a new line double block indented and insert:

"**(G) The waiver of coverage does not apply to coverage required under state law.**

(H)".

Page 4, line 4, delete "(b)(1)" and insert "**(b)(2)(A)**".

Page 4, line 6, delete "(b)(2)" and insert "**(b)(2)(B)**".

Page 4, delete lines 8 through 20, begin a new paragraph and insert:

"**(d) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:**

(1) written notice under subsection (b)(2)(A); and

(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).

(e) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.

(f) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.

(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.

(h) Upon the expiration of the waiver period allowed under this section, the insurer shall:

(1) remove the waiver;

(2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and

(3) renew the policy in accordance with 45 CFR 148.122.".

Page 5, line 20, strike "full-time" and insert "**full time**".

Page 6, between lines 26 and 27, begin a new paragraph and insert:

"SECTION 4. IC 27-8-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]:

Chapter 13.5. Health Benefit Mandate Option

Sec. 1. As used in this chapter, "health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, a policy of accident and sickness insurance, to the extent that the coverage is not required under federal law:

(1) Newborn coverage under IC 27-8-5.6.

(2) Breast cancer screening related coverage under IC 27-8-14.

(3) Morbid obesity related coverage under IC 27-8-14.1.

(4) Pervasive developmental disability related coverage under IC 27-8-14.2.

(5) Diabetes related coverage under IC 27-8-14.5.

(6) Prostate cancer screening related coverage under IC 27-8-14.7.

(7) Colorectal cancer screening related coverage under IC 27-8-14.8.

(8) Off label drug treatment coverage under IC 27-8-20.

(9) Minimum maternity related benefits under IC 27-8-24.

(10) Inherited metabolic disease related coverage under IC 27-8-24.1.

(11) Mastectomy related coverage under IC 27-8-5-26.

(12) Mental illness related coverage under IC 27-8-5-15.6.

(13) Dental anesthesia related coverage under IC 27-8-5-27.

(14) Adopted child coverage under IC 27-8-5-21.

Sec. 2. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues or delivers a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.

Sec. 4. As used in this chapter, "prospective purchaser" means an:

(1) individual who requests coverage under a policy of accident and sickness insurance issued on an individual basis; or

(2) employer that:

(A) employs not more than fifty (50) employees;

(B) requests coverage for the employer's employees under a policy of accident and sickness insurance issued on a group basis; and

(C) has not provided coverage for health care services (as defined in IC 27-13-1-18) for the employer's employees during the preceding calendar year.

Sec. 5. Notwithstanding any other law, an insurer may offer to a prospective purchaser a policy of accident and sickness insurance without complying with all health benefit mandates if:

(1) when the offer is made, the insurer provides a list of the health benefit mandates with which the offer does not comply; and

(2) the policy offered includes the following:

(A) Newborn coverage required under IC 27-8-5.6.

(B) Diabetes related coverage required under IC 27-8-14.5.

(C) If the prospective purchaser is described in section 4(2) of this chapter:

(i) breast cancer screening related coverage required under IC 27-8-14;

(ii) prostate cancer screening related coverage required under IC 27-8-14.7; and

(iii) colorectal cancer screening related coverage required under IC 27-8-14.8.

(D) Adopted child coverage required under IC 27-8-5-21.

(E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).

Sec. 6. An insurer that offers to a prospective purchaser a policy of accident and sickness insurance described in section 5 of this chapter shall also offer to the prospective purchaser a policy of accident and sickness insurance in compliance with all health benefit mandates.

Sec. 7. An insurer that issues or delivers a policy of accident and sickness insurance described in section 5 of this chapter shall provide to an individual insured under the policy of accident and sickness insurance a written disclosure that:

(1) acknowledges that the policy of accident and sickness insurance is not issued in compliance with all health benefit mandates; and

(2) lists in summary form the health benefits:

(A) to which a health benefit mandate applies; and

(B) for which coverage is provided in the policy of accident and sickness insurance.

SECTION 5. IC 27-8-29-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

(1) grievance filed under IC 27-8-28; or

(2) denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3.**

SECTION 6. IC 27-8-29-12 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity;

(3) a determination that a proposed service is experimental or investigational; or

(4) a denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3;**

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 7. IC 27-8-29-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:

(A) appeal resolution under IC 27-8-28-17; or

(B) denial of coverage based on a waiver described in IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3;**

not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each

external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 8. IC 27-8-29-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within three (3) business days after the

external grievance is filed; or

(2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

(c) In an external grievance described in section 12(4) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5, ~~or~~ **IC 27-8-5-2.7,** IC 27-8-5-19.2, **or IC 27-8-5-19.3.**

(d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

SECTION 9. IC 27-13-1-17.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 17.6. "Health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, an individual contract or a group contract, to the extent that the coverage is not required under federal law:**

(1) Newborn coverage under IC 27-8-5.6.

(2) Breast cancer screening related coverage under

IC 27-13-7-15.3.

(3) Morbid obesity related coverage under IC 27-13-7-14.5.

(4) Pervasive developmental disability related coverage under IC 27-13-7-14.7.

(5) Diabetes related coverage under IC 27-8-14.5.

(6) Prostate cancer screening related coverage under IC 27-13-7-16.

(7) Colorectal cancer screening related coverage under IC 27-13-7-17.

(8) Off label drug treatment coverage under IC 27-8-20.

(9) Minimum maternity related benefits under IC 27-8-24.

(10) Inherited metabolic disease related coverage under IC 27-13-7-18.

(11) Mastectomy related coverage under IC 27-13-7-14.

(12) Mental illness related coverage under IC 27-13-7-14.8.

(13) Dental anesthesia related coverage under IC 27-13-7-15.

(14) Adopted child coverage under IC 27-8-5-21.

SECTION 10. IC 27-13-1-27.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 27.8. "Prospective purchaser" means an:**

(1) individual who requests coverage under an individual contract; or

(2) employer that:

(A) employs not more than fifty (50) employees;

(B) requests coverage for the employer's employees under a group contract; and

(C) has not provided coverage for health care services for the employer's employees during the preceding calendar year.

SECTION 11. IC 27-13-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]:

Chapter 7.5. Health Benefit Mandate Option

Sec. 1. Notwithstanding any other law, a health maintenance organization may offer to a prospective purchaser an individual contract or a group contract without complying with all health benefit mandates if:

(1) when the offer is made, the health maintenance organization provides a list of the health benefit mandates with which the offer does not comply; and

(2) the contract includes the following:

(A) Newborn coverage that is substantially similar to the coverage required under IC 27-8-5.6.

(B) Diabetes related coverage required under IC 27-8-14.5.

(C) If the prospective purchaser is described in IC 27-13-1-27.8(2):

(i) breast cancer screening related coverage required under IC 27-13-7-15.3;

(ii) prostate cancer screening related coverage required under IC 27-13-7-16; and

(iii) colorectal cancer screening related coverage required under IC 27-13-7-17.

(D) Adopted child coverage required under IC 27-8-5-21.

(E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).

Sec. 2. A health maintenance organization that offers to a prospective purchaser an individual contract or a group contract described in section 1 of this chapter shall also offer to the prospective purchaser an individual contract or a group contract in compliance with all health benefit mandates.

Sec. 3. A health maintenance organization that enters into or delivers an individual contract or a group contract described in section 1 of this chapter shall provide to an enrollee a written disclosure that:

(1) acknowledges that the individual contract or group contract is not entered into in compliance with all health benefit mandates; and

(2) lists in summary form the health benefits:

(A) to which a health benefit mandate applies; and

(B) for which coverage is provided in the individual contract or group contract.

SECTION 12. [EFFECTIVE JULY 1, 2005] **(a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.**

(b) An insurer that issues or delivers a policy of accident and sickness insurance described in IC 27-8-13.5-5, as added by this act, and a health maintenance organization that enters into or delivers a contract described in IC 27-13-7.5-1, as added by this act, shall report the following information to the department not later than November 15, 2006:

(1) The number of policies or contracts described in this subsection that are issued or delivered by the insurer or entered into or delivered by the health maintenance organization and the number of individuals covered under each policy or contract.

(2) The premium for each policy or contract described in this subsection.

(3) The difference between:

(A) the premium described in this subsection; and

(B) the premium of any other policy or contract offered to a prospective purchaser that purchased a policy or contract described in this subsection.

(c) Not later than December 1, 2006, the department shall compile the information reported to the department under subsection (b) and report the information to the legislative council in an electronic format under IC 5-14-6. The department:

(1) shall include in the report information concerning the number of uninsured individuals in Indiana; and

(2) may include any other information in the report that the department determines is relevant.

(d) This SECTION expires December 31, 2006.".

Page 6, line 27, delete "and" and insert "**,**".

Page 6, line 28, delete "IC 27-8-5-19.3, both".

Page 6, line 28, delete "apply" and insert "**applies**".

Page 6, line 29, delete ", delivered, amended," and insert "**or delivered**".

Page 6, line 30, delete "or renewed".

Page 6, after line 30, begin a new paragraph and insert:

"SECTION 14. [EFFECTIVE JULY 1, 2005] **(a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.7 or IC 27-8-5-19.3, both as added by this act, shall submit to the commissioner of the department of**

insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:

(1) The number of policies and certificates that the insurer issued with a waiver.

(2) A list of specified conditions that the insurer waived.

(3) The number of waivers issued for each specified condition listed under subdivision (2).

(4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.

(5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.

(b) An insurer shall submit to the commissioner of the department of insurance the information required under subsection (a) as follows:

(1) Not later than September 1, 2006, for the reporting period July 1, 2005, through June 30, 2006.

(2) Not later than September 1, 2007, for the reporting period July 1, 2006, through June 30, 2007.

(c) The commissioner of the department of insurance shall forward the information submitted:

(1) under subsection (b)(1) not later than November 1, 2006; and

(2) under subsection (b)(2) not later than November 1, 2007;

to the legislative council in an electronic format under IC 5-14-6.

(d) The commissioner of the department of insurance shall compile the information submitted under subsection (b) and, not later than November 1, 2007, report the information to the

legislative council in an electronic format under IC 5-14-6.

(e) This SECTION expires June 30, 2008.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1075 as reprinted January 25, 2005.)

and when so amended that said bill do pass.

Committee Vote: Yeas 6, Nays 3.

_____

Miller **Chairperson**